COVID-19 Vaccine Attestation Form

MassHealth Home and Community-based Services MFP Waivers Self-Directed Program

This form will help your Waiver Participant Consumer-employer verify your vaccine status and make decisions about their safety and personal care. **Any Direct Care Worker who refuses to complete this form and/or comply with regulations promulgated, or regulations issued, by the Department of Public Health (DPH) pertaining to COVID-19 vaccination requirements may be subject to termination, as determined by their Waiver Participant Consumer-employer.**

By signing below, I acknowledge the following:

- I understand that Direct Care Workers (DCWs) working in the MassHealth Home and Community-based Services MFP Waivers Self-Directed Program are required to complete the full regimen of COVID-19 vaccine doses by October 31, 2021, per the Massachusetts Department of Public Health regulation 105 CMR 159.000: *COVID-19 Vaccinations for Certain Staff Providing Home Care Services in Massachusetts*;
- I have received information regarding the risks and benefits of receiving a COVID-19 vaccine, which includes information available at https://www.mass.gov/info-details/massachusetts-law-about-vaccination-immunization;
- I understand that under state and federal employment law, my Waiver Participant Consumer-employer has a legal right to require that I receive a COVID-19 vaccine as a condition of employment. **My Waiver Participant Consumer-employer can make hiring, termination, and scheduling decisions based on this requirement**;
- I can produce proof of my vaccination status or proof supporting a qualified exemption;
- I understand that if I qualify for an exemption or if I otherwise do not get the vaccine, I may be at greater risk of contracting COVID-19 and/or spreading it to others; and
- I understand that my Waiver Participant Consumer-employer may choose to terminate employment even if I qualify for an exemption if I cannot perform my essential job functions through a reasonable accommodation without creating an undue burden on my Waiver Participant Consumer-employer.

DCW Vaccine Status

By signing below, I attest to the following under the pains and penalties of perjury (please check one):

☐ I have completed the full regimen of COVID-19 vaccine doses. Specifically, I have received two doses of the Pfizer-BioNTech vaccine, or two doses of the Moderna vaccine, or one dose of the Johnson & Johnson vaccine.

☐ I am requesting a COVID-19 vaccine exemption based on one of the following (please check one):

- ☐ A licensed independent practitioner who has a practitioner/patient relationship with me has determined that administration of the COVID-19 vaccine is medically contraindicated, meaning the COVID-19 vaccine would likely be detrimental to my health, and I have documentation from said licensed independent practitioner demonstrating this determination; or
- ☐ I object to receiving a COVID-19 vaccine based on a sincerely held religious belief and I have documentation demonstrating this sincerely held religious belief.

☐ I am not currently vaccinated against COVID-19 and am not requesting (or do not qualify for) an exemption.

DCW Name	DCW Signature	Date Signed
Waiver Participant Consumer Name	Waiver Participant Consumer, Surrogate, or Legal Guardian Signature	Date Signed